



## Complete Summary

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### TITLE

Chronic obstructive pulmonary disease (COPD): hospital admission rate.

### SOURCE(S)

AHRQ quality indicators. Guide to prevention quality indicators: hospital admission for ambulatory care sensitive conditions [version 3.1]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2007 Mar 12. 59 p.(AHRQ Pub; no. 02-R0203).

AHRQ quality indicators. Prevention quality indicators: technical specifications [version 3.2]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008 Feb 29. 22 p.

## Measure Domain

### PRIMARY MEASURE DOMAIN

Population Health

The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the [Measure Validity](#) page.

### SECONDARY MEASURE DOMAIN

Access

## Brief Abstract

### DESCRIPTION

This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.

As a Prevention Quality Indicator (PQI), COPD is not a measure of hospital quality, but rather one measure of outpatient and other health care. This indicator has unclear construct validity, because it has not been validated except as part of a set of indicators. Providers may reduce admission rates without actually improving quality by shifting care to an outpatient setting. Some COPD care takes place in emergency rooms, so combining inpatient and emergency room data may give a more accurate picture.

## RATIONALE

Prevention is an important role for all health care providers. Providers can help individuals stay healthy by preventing disease, and they can prevent complications of existing disease by helping patients live with their illnesses. To fulfill this role, however, providers need data on the impact of their services and the opportunity to compare these data over time or across communities. Local, State, and Federal policymakers also need these tools and data to identify potential access or quality-of-care problems related to prevention, to plan specific interventions, and to evaluate how well these interventions meet the goals of preventing illness and disability.

While these indicators use hospital inpatient data, their focus is an outpatient health care. Except in the case of patients who are readmitted soon after discharge from a hospital, the quality of inpatient care is unlikely to be a significant determinant of admission rates for ambulatory care sensitive conditions. Rather, the Prevention Quality Indicators (PQIs) assess the quality of the health care system as a whole, and especially the quality of ambulatory care, in preventing medical complications. As a result, these measures are likely to be of the greatest value when calculated at the population level and when used by public health groups, State data organizations, and other organizations concerned with the health of populations.

These indicators\* serve as a screening tool rather than as definitive measures of quality problems. They can provide initial information about potential problems in the community that may require further, more in-depth analysis.

Chronic obstructive pulmonary disease (COPD) comprises three primary diseases that cause respiratory dysfunction--asthma, emphysema, and chronic bronchitis--each with distinct etiologies, treatments, and outcomes. This indicator examines emphysema and bronchitis; asthma is discussed separately for children (see the related National Quality Measures Clearinghouse [NQMC] summary of the Agency for Healthcare Research and Quality [AHRQ] indicator [Asthma Admission Rate \(Area Level\): Rate per 100,000 Population](#)) and adults (see the related NQMC summary of the AHRQ indicator [Adult Asthma: Hospital Admission Rate](#)).

Proper outpatient treatment may reduce admissions for COPD.

\*The following caveats were identified from the literature review for the "Chronic Obstructive Pulmonary Disease Admission Rate" indicator:

- *Proxy*<sup>a</sup>: Indicator does not directly measure patient outcomes but an aspect of care that is associated with the outcome; thus, it is best used with other indicators that measure similar aspects of care.
- *Confounding bias*<sup>a</sup>: Patient characteristics may substantially affect the performance of the indicator; risk adjustment is recommended.
- *Easily manipulated*<sup>a</sup>: Use of the indicator may create perverse incentives to improve performance on the indicator without truly improving quality of care.
- *Unclear benchmark*<sup>b</sup>: The "correct rate" has not been established for the indicator; national, regional, or peer group averages may be the best benchmark available.

Refer to the original measure documentation for further details.

**Note:**

**a** - The concern is theoretical or suggested, but no specific evidence was found in the literature.

**b** - Indicates that the concern has been demonstrated in the literature.

**PRIMARY CLINICAL COMPONENT**

Chronic obstructive pulmonary disease (COPD); hospital admission rates

**DENOMINATOR DESCRIPTION**

Population in Metro Area or county, age 18 years and older

**NUMERATOR DESCRIPTION**

All non-maternal discharges, age 18 years and older, with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) principal diagnosis code\* for chronic obstructive pulmonary disease (COPD)

Exclude cases:

- Transferring from another institution
- Major Diagnostic Category (MDC) 14 (pregnancy, childbirth, and puerperium)
- MDC 15 (newborn and other neonates)

\*Refer to the Technical Specifications document for specific ICD-9-CM codes.

**Evidence Supporting the Measure**

**EVIDENCE SUPPORTING THE VALUE OF MONITORING THE ASPECT OF POPULATION HEALTH**

- One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

**Evidence Supporting Need for the Measure**

**NEED FOR THE MEASURE**

Monitoring health state(s)  
Variation in health state(s)

**EVIDENCE SUPPORTING NEED FOR THE MEASURE**

AHRQ quality indicators. Guide to prevention quality indicators: hospital admission for ambulatory care sensitive conditions [version 3.1]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2007 Mar 12. 59 p.(AHRQ Pub; no. 02-R0203).

## State of Use of the Measure

### STATE OF USE

Current routine use

### CURRENT USE

Monitoring health state(s)  
National reporting

## Application of Measure in its Current Use

### CARE SETTING

Ambulatory Care  
Community Health Care

### PROFESSIONALS RESPONSIBLE FOR HEALTH CARE

Advanced Practice Nurses  
Physician Assistants  
Physicians  
Public Health Professionals

### LOWEST LEVEL OF HEALTH CARE DELIVERY ADDRESSED

Counties or Cities

### TARGET POPULATION AGE

Age greater than or equal to 18 years

### TARGET POPULATION GENDER

Either male or female

### STRATIFICATION BY VULNERABLE POPULATIONS

Unspecified

## Characteristics of the Primary Clinical Component

### INCIDENCE/PREVALENCE

Unspecified

### ASSOCIATION WITH VULNERABLE POPULATIONS

Millman et al. found that low-income zip codes had 5.8 times more chronic obstructive pulmonary disease (COPD) hospitalizations per capita than high-income zip codes.

## **EVIDENCE FOR ASSOCIATION WITH VULNERABLE POPULATIONS**

Millman M, editor(s). Access to health care in America. Committee on Monitoring Access to Personal Health Care Services. Washington (DC): National Academy Press; 1993. 240 p.

## **BURDEN OF ILLNESS**

Unspecified

## **UTILIZATION**

Unspecified

## **COSTS**

Unspecified

# **Institute of Medicine National Healthcare Quality Report Categories**

## **IOM CARE NEED**

Living with Illness

## **IOM DOMAIN**

Effectiveness  
Timeliness

# **Data Collection for the Measure**

## **CASE FINDING**

Both users and nonusers of care

## **DESCRIPTION OF CASE FINDING**

Population in Metro Area or county, age 18 years and older

## **DENOMINATOR SAMPLING FRAME**

Geographically defined

## **DENOMINATOR INCLUSIONS/EXCLUSIONS**

**Inclusions**

Population in Metro Area or county, age 18 years and older

**Exclusions**

Unspecified

**RELATIONSHIP OF DENOMINATOR TO NUMERATOR**

All cases in the denominator are not equally eligible to appear in the numerator

**DENOMINATOR (INDEX) EVENT**

Patient Characteristic

**DENOMINATOR TIME WINDOW**

Time window is a single point in time

**NUMERATOR INCLUSIONS/EXCLUSIONS****Inclusions**

All non-maternal discharges, age 18 years and older, with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) principal diagnosis code\* for chronic obstructive pulmonary disease (COPD)

\*Refer to the Technical Specifications document for specific ICD-9-CM codes.

**Exclusions**

Exclude cases:

- Transferring from another institution
- Major Diagnostic Category (MDC) 14 (pregnancy, childbirth, and puerperium)
- MDC 15 (newborn and other neonates)

**MEASURE RESULTS UNDER CONTROL OF HEALTH CARE PROFESSIONALS, ORGANIZATIONS AND/OR POLICYMAKERS**

The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.

**NUMERATOR TIME WINDOW**

Institutionalization

**DATA SOURCE**

Administrative data

**LEVEL OF DETERMINATION OF QUALITY**

Does not apply to this measure

#### **TYPE OF HEALTH STATE**

Adverse Health State

#### **PRE-EXISTING INSTRUMENT USED**

Unspecified

### **Computation of the Measure**

#### **SCORING**

Rate

#### **INTERPRETATION OF SCORE**

A lower score is desirable

#### **ALLOWANCE FOR PATIENT FACTORS**

Analysis by subgroup (stratification on patient factors, geographic factors, etc.)  
Risk adjustment method widely or commercially available

#### **DESCRIPTION OF ALLOWANCE FOR PATIENT FACTORS**

Observed (raw) rates may be stratified by areas (Metro Areas or counties), age groups, race/ethnicity categories, and sex.

Risk adjustment of the data is recommended using age and sex.

Application of multivariate signal extraction (MSX) to smooth risk adjusted rates is also recommended.

#### **STANDARD OF COMPARISON**

External comparison at a point in time  
External comparison of time trends  
Internal time comparison

### **Evaluation of Measure Properties**

#### **EXTENT OF MEASURE TESTING**

Each potential quality indicator was evaluated against the following six criteria, which were considered essential for determining the reliability and validity of a quality indicator: face validity, precision, minimum bias, construct validity, fosters real quality improvement, and application. The project team searched Medline for

articles relating to each of these six areas of evaluation. Additionally, extensive empirical testing of all potential indicators was conducted using the 1995-97 Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID) and Nationwide Inpatient Sample (NIS) to determine precision, bias, and construct validity. Table 1 in the original measure documentation summarizes the results of the literature review and empirical evaluations on the Prevention Quality Indicators (PQI). Refer to the original measure documentation for details.

## **EVIDENCE FOR RELIABILITY/VALIDITY TESTING**

AHRQ quality indicators. Guide to prevention quality indicators: hospital admission for ambulatory care sensitive conditions [version 3.1]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2007 Mar 12. 59 p.(AHRQ Pub; no. 02-R0203).

### **Identifying Information**

#### **ORIGINAL TITLE**

Chronic obstructive pulmonary disease (COPD) admission rate (PQI 5).

#### **MEASURE COLLECTION**

[Agency for Healthcare Research and Quality \(AHRQ\) Quality Indicators](#)

#### **MEASURE SET NAME**

[Agency for Healthcare Research and Quality \(AHRQ\) Prevention Quality Indicators](#)

#### **DEVELOPER**

Agency for Healthcare Research and Quality

#### **FUNDING SOURCE(S)**

Agency for Healthcare Research and Quality (AHRQ)

#### **COMPOSITION OF THE GROUP THAT DEVELOPED THE MEASURE**

The Agency for Healthcare Research and Quality (AHRQ) Quality Indicators are in the public domain and the specifications come from multiple sources, including the published and unpublished literature, users, researchers, and other organizations. AHRQ as an agency is responsible for the content of the indicators.

#### **FINANCIAL DISCLOSURES/OTHER POTENTIAL CONFLICTS OF INTEREST**

None

#### **ENDORSER**



National Quality Forum

**INCLUDED IN**

National Healthcare Disparities Report (NHDR)

**ADAPTATION**

This indicator was originally developed by Billings and colleagues in conjunction with the United Hospital Fund of New York.

**PARENT MEASURE**

Unspecified

**RELEASE DATE**

2001 Oct

**REVISION DATE**

2008 Feb

**MEASURE STATUS**

This is the current release of the measure.

This measure updates previous versions:

- AHRQ quality indicators. Guide to prevention quality indicators: hospital admission for ambulatory care sensitive conditions [version 3.0a]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2006 Feb 20. 58 p. (AHRQ Pub; no. 02-R0203).
- AHRQ quality indicators. Prevention quality indicators: technical specifications [version 3.1]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2007 Mar 12. 22 p.

**SOURCE(S)**

AHRQ quality indicators. Guide to prevention quality indicators: hospital admission for ambulatory care sensitive conditions [version 3.1]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2007 Mar 12. 59 p.(AHRQ Pub; no. 02-R0203).

AHRQ quality indicators. Prevention quality indicators: technical specifications [version 3.2]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008 Feb 29. 22 p.

**MEASURE AVAILABILITY**

The individual measure, "Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (PQI 5)," is published in "AHRQ Quality Indicators. Guide to Prevention Quality Indicators" and "AHRQ Quality Indicators. Prevention Quality Indicators: Technical Specifications." These documents are available in Portable Document Format (PDF) from the [Prevention Quality Indicators Download](#) page at the Agency for Healthcare Research and Quality (AHRQ) Quality Indicators Web site.

For more information, please contact the QI Support Team at [support@qualityindicators.ahrq.gov](mailto:support@qualityindicators.ahrq.gov).

## COMPANION DOCUMENTS

The following are available:

- AHRQ quality indicators. Prevention quality indicators: software documentation [version 3.2] - SAS. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008 Mar 10. 32 p. This document is available in Portable Document Format (PDF) from the [AHRQ Quality Indicators Web site](#).
- AHRQ quality indicators. Software documentation: Windows [version 3.2]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008 Mar 10. 99 p. This document is available in PDF from the [AHRQ Quality Indicators Web site](#).
- Prevention quality indicators (PQI): covariates [version 3.1]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2007 Mar 12. 17 p. This document is available in PDF from the [AHRQ Quality Indicators Web site](#).
- Prevention quality indicators (PQI): covariates (age only) [version 3.1]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2007 Mar 12. 17 p. This document is available in PDF from the [AHRQ Quality Indicators Web site](#).
- Remus D, Fraser I. Guidance for using the AHRQ quality indicators for hospital-level public reporting or payment. Rockville (MD): Agency for Healthcare Research and Quality; 2004 Aug. 24 p. This document is available in PDF from the [AHRQ Quality Indicators Web site](#).
- UCSF-Stanford Evidence-based Practice Center. Davies GM, Geppert J, McClellan M, et al. Refinement of the HCUP quality indicators. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2001 May. (Technical review; no. 4). This document is available in PDF from the [AHRQ Quality Indicators Web site](#).
- HCUPnet. [internet]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2004 [accessed 2007 May 21]. [Various pagings]. HCUPnet is available from the [AHRQ Web site](#). See the related [QualityTools](#) summary.

## NQMC STATUS

This NQMC summary was completed by ECRI on December 19, 2002. The information was verified by the Agency for Healthcare Research and Quality on January 9, 2003. This NQMC summary was updated by ECRI Institute on April 6, 2004, February 18, 2005, February 27, 2006, June 15, 2007 and again on November 26, 2008.

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